Inadequate emergency care

SIR,—It is interesting that Professor Miles Irving's letter on the closure of the Medical Research Council trauma unit and the revelation that only 0·5% of the MRC budget is spent on trauma research is mirrored by the correspondence on the management of spinal cord injury at the accident. It is no surprise, if so little is spent on trauma research, that so little teaching is given at medical school and therefore that trauma is so often misunderstood. If the mechanism of injury was properly studied and the patterns of injury properly recognised then the management of each case would be self evident and not based on "standard" procedure. Attendance at accidents soon confirms that a much deeper understanding of trauma is required to manage casualties to the highest standard: one cannot just follow rules slavishly, that is what is wrong with much that is written and taught on the subject of trauma. For instance, where else in medicine would one find such meaningless nomenclature as the "whiplash" injury, which completely misrepresents what happens. Moreover, I have even read papers on the cause of road accident injuries in which the author has actually admitted that he has not even looked at the vehicles, only the patients.

Professor Irving's revelations now explain why research money is so hard to find, as I can confirm, and why it is so difficult to initiate advancements in managing trauma. The difficulties are to be encountered not only in research, but also at DHSS, regional, and local level in management, education, and clinical practice. Even the ambulance service is no exception.

Trauma is about young, fit, healthy patients who are damaged, not diseased, and can be repaired to continue a productive, useful, happy life. They surely deserve the highest standard of care but will they get it without good research and teaching? If after leaving medical school many junior doctors do not even know how to resuscitate a patient then perhaps this too should be regarded as indicative of the poor level of investment in the subject of trauma. Over 10 years ago I showed that a flying squad service could be cost effective and integrated into a system of training and research to upgrade emergency care. The system fails because it has to be paid for out of one budget to produce savings in another. A fatal road accident can cost the community well over £125 000, and how much does it cost to support a young quadraplegic for 20 years? The French SAMU, Danish Falck-Zonen, and German rescue systems all uphold the principles of research and development of new concepts of trauma care. Can we really afford to neglect such an important area of medicine? We cannot lead the field on an investment of 0·5%.

R SNOOK

Royal United Hospital,
Combe Park,
Bath BA1 3NG

Taking money from the devil

SIR,—I was dismayed on returning from a trip to the Far East to find your leading article about one of the trusts with which I am concerned associating it with the works of the devil (21-28 December, p 1743).

I and all the other trustees of the Health Promotion Research Trust have been, are, and will remain antismoking. We have had a policy until now of avoiding self defence in the face of critical and hostile attacks, and at this stage I certainly do not wish to take up your space and your readers' time with a detailed correction of all the errors in your article. I would, however, like you and your readers to know that it contains serious errors and is based on a completely false assertion about the trustees' and my own activities when the trust deed was drawn up. Why your leader writer did not read and quote more accurately the Health Promotion Research Trust's annual report for 1984 is not for me to say, but I refer interested readers either to that document or to the Health Minister's statement in the House of Commons in July 1983 (Hansard, July 17, 1983. Volume 46 C510-1-W).

Concerning the devil, surely we are not going to have to go back to the Middle Ages and wrestle all over again with assertions about his being everywhere, in breweries, distilleries, car factories, and so on, and argue whether or not his money is mingled with all the salary cheques and wage packages of government paid employees?

The Health Promotion Research Trust has now committed over half its money; over 400 interesting and impressive applications for research support have been received and are being processed by our large panel of distinguished professional referees. Judging by past form, your latest leading article will probably yield more to heighten the competition for our remaining resources. We must be grateful for such indirect help.

JOHN BUTTERFIELD

Cambridge University School of Clinical Medicine,
Addenbrooke's Hospital,
Cambridge CB2 2QQ

SIR,—Having played a small part in the last few years in deciding how one part of the drink industry, the Scotch Whisky Association, disburses money for alcohol education and research, I am writing to comment on your leading article (21-28 December, p 1743). I exhort my children never to smoke but counsel them to use alcohol sensibly. If they drink they may suffer harm; if they smoke they undoubtedly will.

The Scotch Whisky Association has agreed that the recipients of all its research grants should be free to publish any findings without reference to the association whether or not they might be seen to be damaging to the interests of the industry. In its funding of the Alcohol Research Group at the University of Edinburgh; of the Scottish Council on Alcoholism with its network of affiliated councils; of general practice research at Dundee University; and of the Medical Council on Alcoholism with its publications and programmes for medical students, nurses, and graduate doctors and in its pioneering of company alcohol policies in Scotland, the industry itself has done much to bring about the situation which led you to entitle another leading article, "Scots lead the way on alcohol."[1] This statement is true not only of Sir John Crofton's immense contribution, *Health Education in the Prevention of Alcohol Related Problems*,[2] but also of the healthy state and international reputation of alcohol research in Scotland and, more importantly, of the growth of community services for those with alcohol related problems.

A cynic might say that I am simply bearing witness to the drink industry buying respectability, but having worked for 15 years with decent men in the industry from malt barns to board rooms, men who do have social consciences and misgivings about the effects of their products on the vulnerable and who do their best to present a balanced view of the health aspects of the industry to visitors from medicine and the social sciences, I despair at such tub thumping and the oversimplification of complex issues.

IAN CUNNINGHAM

Health Centre,
Dufftown,
Keith,
Banffshire AB5 4BH

1 Anonymous. Scots lead the way on alcohol [Editorial]. *Br Med J* 1985;**290**:952-3.
2 Scottish Health Education Coordinating Committee. *Health education in the prevention of alcohol related problems*. Edinburgh: SHHD, 1985.

The kidney in myeloma

SIR,—We read with interest the leading article by Dr T J Hamblin (4 January, p 2) and would agree that patients with renal amyloidosis seem to have a poor prognosis when receiving long term dialysis. In our collective series of 389 patients with end stage renal failure accepted for dialysis (either haemodialysis or continuous ambulatory peritoneal dialysis) analysed using multiple regression with the method of Cox,[1] we found that amyloidosis, irrespective of the underlying aetiology, is a highly significant risk factor. Its presence multiplies the risk of death in a given period by a factor of 8·5 ($p<0·0001$, 95% confidence limits 3·29-22·0).

We are, however, concerned about the ambiguity of the last sentence: "though systemic amyloidosis in myeloma is usually rapidly lethal its progression is sometimes slow; it is well worth persevering with treating the myeloma and the renal failure with supportive measures short of long term dialysis." Several studies[2,3] have shown an improved prognosis in patients with myeloma, and despite our observations we think that patients with amyloidosis should not necessarily be excluded from long term dialysis. It is well known that in the UK fewer patients are accepted for long term dialysis than in most other European countries,[4] and a recent survey suggests that failure of referral contributes significantly to the low acceptance rates.[5] We would therefore recommend that all patients with myeloma who develop renal failure, with or without amyloid, should be referred to a renal unit for consideration of long term dialysis.

D C WHEELER
J FEEHALLY
P BURTON
J WALLS

Department of Nephrology,
Leicester General Hospital,
Leicester LE5 4PW

1 Cox D. Regression models and life tables. *Journal of the Royal Statistical Society* (Series B) 1972;**34**:197-220.
2 Medical Research Council. Working Party on Leukaemia in Adults. Analysis and management of renal failure in fourth MRC myelomatosis trial. *Br Med J* 1984;**288**:1411-6.
3 Coward RA, Mallick NP, Delamore IW. Should patients with renal failure associated with myeloma be dialysed? *Br Med J* 1983;**287**:1575-8.
4 Kramer P, Broyer M, Brunner FP. Combined report of regular dialysis and transplantation in Europe XIV, 1983. *Proc Eur Dial Transplant Assoc* 1983;**21**:5-66.
5 Challah S, Wing AJ, Bauer R, Morris RW, Schroeder SA. Negative selection of patients for dialysis and transplantation in the United Kingdom. *Br Med J* 1984;**288**:1119-22.

SIR,—In his succinct review of the renal aspects of myeloma (4 January, p 2) Dr T J Hamblin suggests that the treatment of the renal failure which may accompany myeloma should stop short of long term dialysis. Chronic dialysis is of benefit to some patients, as illustrated by the following case.

A 66 year old man was admitted in end stage renal failure with a creatinine concentration of 1600 µmol/l (16·5 mg/100 ml). His immunoglobulins were uniformly depressed and a monoclonal IgG lambda paraprotein was detected in the serum and urine. Renal biopsy showed an interstitial fibrosis and tubular loss but no evidence of amyloid. In spite of acute peritoneal dialysis and strict dietary control, his renal function failed to improve and continuous ambulatory peritoneal dialysis was started.

Over the next four years he received regular chemotherapy with vincristine, prednisolone, and